Updated 11.10.2002

AFP Screening Form

CASE ID:

Patient demographics

Date/time this instrument first initiated: Date: _____/ _____/ _____ (mm/dd/yyyy) Person Receiving Call:

Last name: | First Name:

Address:

Hospital:

Patient agreeable to future follow-up? Yes No

1. Gender
   1. M ale
   2. F emale

2. Date of birth _____/ _____/ _____ (mm/dd/yyyy)

3. Date of illness onset _____/ _____/ _____ (mm/dd/yyyy)

4. Date of hospital admission/first assessment _____/ _____/ _____ | Medical Record Number: _____

5. Contacting Physician: Name

   Street Address:

   City: County: _____

   State: Zip code:

   Telephone number: (_____) _____- _____ Alt Telephone number: (_____) _____-_____

6. Race 1. W hite 2. B lack/ African-American 3. A sian/ Pacific Islander 4. A merican Indian/ Alaska Native 5. Oth er (specify) 9. Unk nown

7. Ethnicity 1. H ispanic 2. Non -Hispanic 9. Unk nown

9. Additional contact information: (close family member/friend) Name:

   Phone:

   Relationship:

10. Primary/Attending MD: Physician Phone:

    Physician Pager/Cell/Fax:

11. Consulting Neurologist (if applicable): Physician Phone:

    Physician Pager/Cell/Fax:

12. Consulting Infectious Disease Physician (if applicable): Physician Phone:

    Physician Pager/Cell/Fax:

AFP Screening Form

CASE ID:

WNV-associated AFP: Presenting signs/symptoms

1. Initial diagnosis:

2. Concurrent symptoms: 1. Fever 2. Headache 3. Nausea/Vomiting 4. M eningismus
5. Altered mental status 6. Other Specify: _____

3. Onset of weakness within first week of illness? 1. Yes 2. No 9. Unk nown
Date of weakness onset: ____/____/_____ (mm/dd/yyyy)

4. Distribution of weakness: 1. Sy mmetric 2. A symmetric 9. Unk nown
Describe weakness distribution: _____

5. Sensory abnormalities present? 1. Yes 2. No 9. Unk nown
Describe sensory abnormalities: _____

6. Pain present? 1. Yes 2. No 9. Unk nown
Description/location of pain: _____

7. Bowel/Bladder involvement present? 1. Yes 2. No 9. Unk nown
Description of bowel/bladder involvement: _____

8. Cerebrospinal fluid evaluation performed? 1. Yes 2. No 9. Unk nown
CSF Results: Protein: Glucose: WBC: RBC:
Gram's stain: Culture:

9. Electromyography/Nerve conduction studies performed? 1. Yes 2. No 9. Unk nown
If yes, date performed: ____/____/_____ (mm/dd/yyyy) Location: _____
Results (description): _____

10. Spinal neuroimaging performed? 1. Yes 2. No 9. Unk nown
If yes, date performed: ____/____/_____ (mm/dd/yyyy)
Results/reading: _____

11. Treatment rendered? 1. Yes 2. No 9. Unk nown
If yes, indicate treatment: 1. IVIG 2. Plasmapheresis 3. Anticoagulation
4. Antibiotics 5. Muscle biopsy 6. Other
Specify if other: _____

11. Serologically confirmed West Nile virus infection? 1. Yes 2. No 9. Unk nown
If yes, results of EIA: _____

Please **Fax** this document to Dr. James Sejvar, Divison of Viral and Rickettsial Diseases, Centers for Disease Control and Prevention, at 404-639-3838. Questions or comments can be directed to 404-639-4657 (Dr. Sejvar)